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Types of health systems reforms in Latin America and results in health access and coverage*

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ABSTRACT

Objective. *Characterize health system reform processes implemented in eight Latin American countries and evaluate their results in terms of health access and coverage conditions.*

Methods. *Data from nationally representative household surveys were used to characterize health system reform processes in Chile, Colombia, El Salvador, Guatemala, Mexico, Paraguay, Peru, and Uruguay and to assess resulting conditions governing health care access and coverage.*

Results. *Five countries introduced changes to expand financial coverage, with a perspective on primary health care limited to the expansion of health service packages, while three countries prioritized changes in health service organization based on a more comprehensive approach to primary health care. Countries in the first group increased insurance coverage but saw no improvement in access to health services. In the second group of countries, important barriers to access continue to exist despite improvements.*

Conclusions. *Health system reforms can be described in terms of the type of reforms promoted. Reforms that focus on expanding insurance coverage improve financial protection but do not result in positive changes in access. Reforms that prioritize reforms in the organization of health services lead to improved access, yet a large proportion of the population continues to report barriers to access in the countries studied. The socioeconomic conditions of the population and unstable policies stand in the way of achieving more significant progress.*

Keywords Health care reform; health services coverage; health services accessibility; primary health care.

The Declaration of Alma-Ata considered health a basic human right and proposed a comprehensive model of care based on primary health care (PHC), which involves health promotion, social participation, and intersectoral coordination to tackle the social determinants of health (1). This declaration was spearheaded by United Nations agencies, national governments, and a host of civil society organizations, who recognized universal access to health services as a basic human right (1, 2).

In the decades after Alma-Ata, many countries in the Region introduced reforms designed to improve access to health and financial protection, increase efficiency in the health services, and reduce inequities (3, 4). The strategies chosen to meet these goals differed between and within countries at different times, ranging from greater government involvement to enhanced market competition, as well as complex mixed approaches. Varying results were achieved in strengthening health systems and moving toward universal

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access to health and universal health coverage (4–6).

In response to the unmet challenges (7), the Member States of the Pan American Health Organization (PAHO) adopted Resolution CD53/5.R14 "Strategy for Universal Access to Health and Universal Health Coverage" (8), containing strategic lines of action to transform or strengthen health systems. (8). PAHO's recent publication, *Health in the Americas+, 2017 edition* (4), distinguishes two types of health system reform, depending on the type of changes in governance: reforms based on changes in health insurance to increase financial coverage of the population, and reforms based on changes in the organizational model of health services, aimed at improving the conditions of access to the services (4). However, there are no systematic studies that would make it possible to characterize these types of reforms and their respective results in health service coverage and access.

Examining the strengths and weaknesses of the different types of health system reform is essential for developing health policies aligned with universal access to health and universal health coverage. In support of this effort, the purpose of this article is to characterize the types of health system reform according to how they were previously defined (4) in eight Latin American countries and to review the results in terms of the conditions of health access and coverage.

MATERIALS AND METHODS

A descriptive approach was used to characterize the health system reform processes of Chile, Colombia, El Salvador, Guatemala, Mexico, Paraguay, Peru, and Uruguay by measuring their conditions of access and coverage in the past five years. These countries were selected because reform processes have been in place there since the 1990s (1993 to 2015) to improve the conditions of access and coverage, and because of the availability of open data from population surveys relevant to this study.

Characterization of reform processes

The reform processes were characterized by the type of reform identified in the PAHO publication (4), which distinguishes two types of health system reform: changes driven by the demand for health services or by the supply of health services.

Reforms centered on changes in the supply of services can be recognized by the presence of innovations in the organizational structures for managing the health services network. These reforms are focused on changes in the model of care and the production of health services. The reforms of demand-driven health systems can be recognized by the introduction of economic incentives in the institutional arrangements governing insurance and the promotion of competition as factors that stimulate changes in the rest of the health system (4).

The following dimensions were considered in characterizing these types of reforms in the countries studied: the defined objectives, the assumed approach to PHC and its scope, and the type of innovations proposed in health system governance. "Governance" is understood as the institutional arrangements that regulate critical health system resources. The approach to PHC was analyzed through the classification of PHC as a package of services, as the first level of care, or as a strategy for transforming the health services system.

This analysis was based on a review of secondary information sources, including indexed publications and studies of reports issued by development agencies and United Nations agencies. Important policy papers and legislative documents from each country were also included. Information was gathered and analyzed using a common matrix for all the countries, organized by the dimensions used to characterize health system reform processes. SciELO, LILACS, ScienceDirect, Elsevier, Google Scholar, MEDLINE, and PubMed were the databases searched to obtain information. The following keywords were used (in English and Spanish): PHC OR primary health care OR health systems, Region of the Americas OR Latin America, health reform OR health care reform OR health sector reform OR national health policy. The literature review was conducted independently by two authors. Only articles in English and Spanish were considered.

Data from the World Bank and the United Nations Development Program (UNDP) were used to explore the gross domestic product (GDP) and human development index (HDI) of the countries studied.

Measurement of health service access and insurance coverage

The conditions of health service access and insurance coverage were analyzed using cross-sectional data from representative national household surveys (Table 1). For trend assessment, the data from at least two different years between 2010 and 2016 were analyzed for each country. To guarantee greater homogeneity among the countries, the variables from all the surveys used in this study were carefully reviewed and selected (Table 2).

Using the Andersen model (9–13), access was measured in this study by the ability to obtain health services when needed. Individuals who had a health problem and responded affirmatively that they had been seen either in a health facility or by a health professional, or by both, represented the population with access to health services. Those who responded negatively were considered to be without access.

The reasons why individuals could not access the health services were divided into seven categories based on the dimensions of access defined by Penchansky and Thomas (14): acceptability (negative perception of the quality of care and treatment by staff), wait time (delays at the health center or wait to obtain an appointment), convenience (lack of time), availability (lack of drugs or health workers), distance (lack of nearby care); economic factors (inability to pay for the services), and cultural factors (mistrust of physicians, language, preference for indigenous, homeopathic , or alternative medicine, or impediments created by a member of the household).

Insurance coverage levels were measured through questions about affiliation with a financial protection or health insurance program. The variables of socioeconomic status found in national surveys were used to calculate the conditions of insurance access and coverage in the poorest and wealthiest segments of the population. Household income was a proxy for socioeconomic status, except in Peru, where household expenditure was used.

RESULTS

Table 3 presents the characterization of the health system reforms. Five countries (Colombia, Chile, Mexico, Peru, and

TABLE 1. Surveys used for evaluating access and coverage in selected Latin American countries

Country	Database	Years	Survey sample	
			Households	Individuals
Chile	National Socioeconomic Characterization Survey (CASEN)	2013	66 725	218 491
		2015	83 887	266 968
Colombia	National Quality of Life Survey (ECD)	2010	14 268	53 453
		2016	22 454	74 349
El Salvador	Multipurpose Household Survey (EHPM)	2011	5 716	10 029
		2016	20 609	70 948
Guatemala	National Survey on Living Conditions (ENCOVI)	2011	13 482	66 523
		2014	11 536	54 822
Mexico	National Household Income and Expenditure Survey (ENIGH)	2012	9 002	33 726
		2014	19 479	73 592
Paraguay	Ongoing Household Survey (EPH)	2012	5 288	21 151
		2016	10 219	37 814
Peru	National Household Survey (ENAHO)	2010	21 496	88 055
		2016	35 785	131 280
Uruguay	Continuous Household Survey (ECH)	2012	43 839	120 462
		2016	45 158	118 591

TABLE 2. Variables used to measure access and insurance coverage levels in selected countries in the Region of the Americas

Variable	Country survey	Type of variable
Access to health services	Chile, Colombia, El Salvador, Guatemala, Mexico, Paraguay, Peru[a]	Categorical: Access = if the individual had an illness or an accident and was treated in a medical facility and/or consulted a physician and/or health professional; No access = if the individual had an illness and did not receive treatment.
	Uruguay[a]	Categorical: Access = if the individual was seen in the medical center of the health insurance system with which he/she was affiliated; No access = if the individual was unable to be treated in the medical center of the health insurance system with which he/she was affiliated.
Insurance coverage	Chile, Colombia, El Salvador, Guatemala, Mexico, Paraguay, Peru, and Uruguay	Categorical: Yes = had insurance; No = did not have insurance

[a] Chile and Paraguay have a three-month reporting period. Colombia, El Salvador, Guatemala, and Peru have a one-month reporting period. El Salvador's survey covers only the population in the public health system. The Mexico and Uruguay surveys do not have a reporting period.

Uruguay) have reforms characterized by the introduction of economic incentives as a strategy for change in health insurance, generally centered on social security. The main objective of these reforms was to expand the explicit coverage of the health services and financial protection. Under this type of system, innovations in governance have focused on changing the mechanisms for regulating the financing model (especially health insurance), with the introduction of market incentives and mechanisms for competition (among resource administrators, service providers, and pharmaceutical companies).

In this type of reform, new regulatory and supervisory agencies are also created, generally with responsibilities in social security; these agencies include superintendencies whose functions involve regulation of the organizations responsible for health service financing (e.g., the superintendencies of Chile and Colombia); in other cases, there is greater involvement of the Ministry of Health, with functions that include the regulation and management of insurance from contributory schemes (e.g., Uruguay's National Board of Health - JUNASA) or of the agencies responsible for public insurance (e.g., Chile's National Health Fund - FONASA). With the exception of Mexico, the reforms of these countries sought a path toward the convergence of public sector and social security insurance mechanisms (Table 3).

The other three countries (Guatemala, Paraguay, and El Salvador) have health system reform policies whose main objective has been to expand the conditions of access through the introduction of changes in their organization, management, and health care models. The changes in governance in these countries were characterized by improvements in health service organization and coordination. The intersectoral approach has been an attribute of the model of care promoted by this type of reform. El Salvador introduced comprehensive PHC through geographically-based community family health teams connected with the network of services and geared to lower-income groups. Paraguay strengthened its model of care with a focus on strengthening the first level care. Guatemala also promoted improvements in the first level of care, although with limited response capacity and integration with the rest of the health services system. These initiatives were confined to the public sector (Table 3).

Results in conditions of insurance access and coverage

Insurance coverage has increased in all the countries except Guatemala and Paraguay. However, only El Salvador, Paraguay, Peru, and Uruguay have achieved lower access barriers to health services (Table 4). According to the latest available data, while insurance coverage ranges from 98% in Chile and Uruguay to 96% in Colombia, 80% in Mexico, and 73% in Peru, it is much lower in Paraguay (24%), El Salvador (24%), and Guatemala (11%). Except in Chile, Peru, and Uruguay, insurance coverage levels are lowest in the poorest 20% of households (Table 4).

High levels of insurance coverage are not always accompanied by better access to health services (Table 4). Except for Chile (7%) and Uruguay (5%), the percentage of the population with access barriers in the countries studied is high: 66% in Peru, 47% in Guatemala, 41% in El Salvador, 26% in Colombia, 25% in Paraguay, and 20% in Mexico. Moreover, access barriers are falling slowly, with differing results in the countries. While the situation in Uruguay and Chile is stable, Colombia and Mexico show higher health service access barriers, both

TABLE 3. Elements of reform processes in selected Latin American countries

Country	Date	Policy	Objectives	Domain[a]	Innovations in governance	Addressing PHC	References
Chile	2005, 2013	Law No. 19,996 establishing the Universal Access Plan with Explicit Guarantees (AUGE)	Guarantee enforceable rights to health services for a number of predefined diseases	Sector public and social security/ private sector	Guarantee of explicit health service coverage, with regulated conditions of quality and access to services	The AUGE reforms assume that PHC is the first level of care in the context of health service delivery networks (in the public sector)	4, 18–23
Colombia	1993, 2012, 2015	Law No. 100 of 1993, Unification of the Health Benefits Plan, Health Statute, 2015	Expand coverage, merge contributory and subsidized systems by standardizing covered benefits; improve conditions for comprehensive coverage	Social security and public sector	Creation of a regulated competitive system with the introduction of private social security resource administrators. Elimination of the criterion for coverage of included services and shift to an exclusions-based benefits regime	PHC has two expressions: in the first stage, as a package of services; and in the last stage, as the strengthening of the first level of care	4, 18, 23, 24
El Salvador	2009	*Construyendo la Esperanza* (Creating Hope)	Guarantee the rural population's access to health services	Public sector	Geographically-based changes in the organization of the health services (community family health teams and teams of specialists), with intersectoral coordination and social participation	PHC as a health system reform strategy	4
Guatemala	1997, 2001, 2011	Program for Expanding the Coverage of Basic Services (1997), Social Development Law (2001), Inclusive Health Model (2011)	Increase equitable access to PHC services by the rural and indigenous population that has difficulty receiving care and lacks the ability to pay	Public sector	Creation of the Comprehensive Health Care System, based on contracts with civil society to deliver health services to the population without access to public facilities, especially rural indigenous communities	In the first stage, development of the first level of care through civil society organizations (CSO) with limited response capacity. In 2001, the MIS promoted the strengthening of primary care, although the scope was limited	4, 25–27
Mexico	2003	General Health Law establishing the Social Protection System in Health (Public Insurance)	Increase public financing to guarantee universal health service coverage	Public sector	Expansion of public financing, with new mechanisms for allocating federal resources to the states and new forms of contracting providers	PHC conceived as the delivery of ambulatory services and the strengthening of primary care through mobile health teams, with health promoters and community health coordinators that provide outreach services	18, 28
Peru	2002, 2009	Comprehensive Health Insurance, Framework Law on Universal Health Insurance (2009)	Gradually expand comprehensive health insurance to all citizens	Public sector and social security	Gradual expansion of SIS (comprehensive health insurance) with government subsidies. Regulations for a basic insurance plan for citizens enrolled in the social security and private insurance systems (2010).	PHC as a package of services in the definition and expansion of the SIS, and first level of care in the Basic Comprehensive Family and Community Health Care Model (MAIS-BFC)	4.18, 29
Paraguay	1996, 2008–2013	Law 1032/96 creating the National Health System; Proposal for Change 2008–2013	Reduce inequity in access by creating primary health care units	Public sector	Strengthening of primary care, with family medicine teams and the elimination of copayments	Creation of Family Care Units as a strategy for strengthening the first level of care	30.
Uruguay	2007 to the present	Law No. 18,211 on the Integrated National Health System	Improve coverage and equity with the expansion of social security insurance and public financing	Social security and public sector	Change in the financing model (greater public financing and equity in insurance) with the creation of the public health fund and promotion of an integrated health care delivery system.	Strengthening of the first level of care in the promotion of health services delivery networks	4, 18, 23

a reforms that influence health service financing and delivery, managed by the ministry of health (or the respective national authority), are considered the purview of the public sector. In the case of Chile, private health insurance institutions (ISAPRES) can be characterized as part of social security, since they receive resources from compulsory contributions; at the same time, however, they can be considered part of the private sector, because of their ability to determine the premiums and coverage of individual health plans, without group insurance mechanisms for the coverage of this population.
PHC=primary health care; MIS=ministry of health.

TABLE 4. Variables of health service access and coverage, health expenditure, and per capita GDP in selected countries, first and last available year

Country	Year	Population without access to services			Insurance coverage			Per capita GDP (US$ at current exchange rates)[a]	Human development index[b]
		Average (%)	Poorest 20% (%)	Richest 20% (%)	Average (%)	Poorest 20% (%)	Richest 20% (%)		
Chile	2013	7	7	6	95	96	95	13 792.9	0. 847
	2015	7	7	6	98	98	98		
Colombia	2010	21	26	14	89	85	95	5 805.6	0. 727
	2016	26	32	19	96	94	97		
El Salvador	2011	43	46	43	17	5	36	4 223.6	0. 680
	2016	41	42	37	24	7	43		
Guatemala	2011	46	52	37	11	4	20	4 146.7	0. 640
	2014	47	56	39	11	2	27		
México	2012	12	15	8	76	76	77	8 208.6	0. 762
	2014	20	25	14	80	78	81		
Paraguay	2012	32	43	24	24	3	58	4 077.7	0. 693
	2016	25	27	22	24	3	58		
Perú	2010	68	76	62	63	72	61	6 049.2	0. 740
	2016	66	69	61	76	82	74		
Uruguay	2012	7	9	6	97	96	98	15 220.6	0. 795
	2016	5	8	5	98	97	99		

GDP=gross domestic product.
Source: 31, 32
[a] Data for 2016.
[b] Data for 2015.

TABLE 5. Types of health service access barriers, selected countries, 2016 (or last available year)

Country	Acceptability			Wait time			Desirability			Availability			Geographical distance			Economic			Cultural		
	Average	Q1	Q5	Average	Q1	Q5	Average	Q1	Q5	Average	Q1	Q5	Average	Q1	Q5	Average	Q1	Q5	Average	Q1	Q5
Chile	ND	ND	ND	1%	2%	1%	4%	4%	5%	ND	ND	ND	2%	3%	0%	4%	4%	3%	24%	27%	15%
Colombia	2%	2%	2%	18%	19%	15%	6%	2%	9%	ND	ND	ND	5%	10%	2%	8%	12%	2%	2%	4%	0%
El Salvador	6%	2%	8%	ND	ND	ND	3%	1%	4%	20%	25%	13%	2%	4%	0%	2%	3%	0%	2%	4%	1%
Guatemala	ND	ND	ND	2%	1%	4%	4%	2%	6%	4%	9%	1%	3%	7%	1%	36%	40%	18%	2%	2%	4%
Mexico	0%	1%	0%	2%	2%	2%	3%	2%	3%	1%	3%	0%	2%	3%	0%	6%	10%	1%	1%	1%	0%
Paraguay	1%	1%	0%	ND	ND	ND	3%	2%	2%	ND	ND	ND	1%	1%	0%	1%	1%	2%	ND	ND	ND
Peru	1%	2%	1%	12%	10%	9%	18%	13%	18%	ND	ND	ND	5%	13%	2%	9%	14%	5%	18%	33%	11%
Uruguay	ND	ND	ND	2%	2%	2%	ND	ND	ND	ND	ND	ND	1%	1%	1%	1%	1%	3%	ND	ND	ND

Q1, poorest 20% of the population; Q5, richest 20% of the population; ND, unavailable in the survey.

nationally and for the poorest segment of the population. Finally, the poorest households are more likely to report access barriers in all the countries studied, with the exception of Chile and Uruguay (Table 4).

Cultural barriers, wait times, and economic barriers were the main reasons why people did not seek health care (Table 5). Cultural barriers were especially important in Chile (24%) and Peru (19%), while wait times were an important factor in Colombia (19%) and Peru (10%). Economic barriers were reported more often in Guatemala (36%), Colombia (10%), and Peru (8%). Every type of barriers was more common in the poorest 20% of the population than in the wealthiest 20% (Table 5).

DISCUSSION

The values of equity, such as achieving health for all, especially for the poorest population, and the introduction of PHC have been key pillars of health system reform in the Region of the Americas in recent decades (3, 4). Indeed, the main messages of the Declaration of Alma-Ata were found in the health system reform policies of the countries studied. However, characterization of these countries' reform processes reveals two types of reform, with different types of interventions assumed to be the drivers of change in health systems—both with potential results in terms of access and coverage.

An initial group of five countries (Colombia [1993, 2012], Chile [2005, 2013], Mexico [2003], Peru [2002, 2009], and Uruguay [2007]) have promoted reforms centered on innovations in insurance models as a strategy for reforming the health system and expanding nominal coverage to ensure that the population is financially protected (4, 18). Despite the introduction of initiatives

promoting a new model of care for the socially marginalized population, the prevailing concepts of PHC are confined to establishing a limited package of services (23). A second group of countries (Paraguay [2008, 2013], El Salvador [2009], and Guatemala [2011]) have focused their interventions on strengthening and reforming the model of care and organizing health services to address the structural fragmentation of health systems. The changes in health service governance in these countries have pursued a comprehensive approach to PHC, with a first level of care that includes health public interventions focused on human rights, social participation, community empowerment, and intersectoral collaboration (27, 30, 35). In El Salvador, changes in health services governance also include new types of regulations to coordinate health service providers with a view to developing integrated networks (35).

These two groups of countries, however, should not be considered homogeneous. The way that segmentation and fragmentation have been addressed reveals specific characteristics.

Although most of the countries that have promoted changes in insurance have extended them beyond the public sector (with the exception of Mexico), there are still constraints to achieving convergence between the different subsystems, both in terms of per-capita investment and standardization of the package of covered services. Only Colombia and Uruguay had interventions designed to bridge the gaps in social security and public sector coverage (36, 37).

Among the countries that focused their efforts on changes in the model of care and the organization of services, only El Salvador has had explicit success in the creation of health service delivery networks. While progress has been observed in strengthening primary care in Paraguay, advances have been more limited in Guatemala. The instability of these policies and the severe vulnerability and social exclusion of much of the population in these countries has limited the progress of these reforms (25–27).

The analysis of health service access and coverage yields potential results for each type of reform that should be explored in greater depth in country-specific case studies. The latest available data show that all the countries that focused on changes in the insurance model have achieved high levels of insurance coverage (80–98% of the population) for both the general population and the poorest 20% (Table 4). Despite the increase in financial coverage, greater access to health services is more limited. Except in Chile and Uruguay, where access barriers are low (7% and 5%, respectively), in Colombia and Mexico 26% and 20% of the population, respectively, still face health service access barriers, with even higher figures for the poorest segment of the population (Table 4). Finally, access barriers in Peru remain high (66%). Weak initiatives for strengthening and reforming the model of care and the organization of health services through a comprehensive approach to PHC could explain these limitations (23, 24).

In the countries that focused on strengthening health service organization, improvements have been observed in access by the poorest population, except in Guatemala (Table 4). A comprehensive PHC approach (El Salvador) and sustained efforts to strengthen the first level of care (Paraguay) are factors that may have facilitated the improvements in access (30, 34). At the same time, insurance coverage in this group of countries has not changed substantially. A clear achievement, however, is the fact that both Paraguay and El Salvador have reduced out-of-pocket expenditures on first-level health services, with low numbers of people reporting lack of access for economic reasons (Table 4). The creation of health teams and new health services in the regions with greater health needs have led to these outcomes (4, 30).

More in-depth analyses of these reform processes could focus on certain future challenges. First, the organizational changes in the different types of health system reform are the result of political processes spearheaded by government action and accompanied by the joint efforts of different social stakeholders. Characterizing the State entities and agencies responsible for developing and implementing these initiatives, and identifying the social stakeholders involved, is an essential part of characterizing the leadership and governance of health system reform processes (4, 5).

Second, analysis of the results of the reform processes, measured in terms of access to health services, should consider factors related to the economic and social context of each country, such as the availability of public resources for investment and the material living conditions of the population. Although the HDI and GDP per capita show clear economic and social differences among the countries studied (Table 4), a more in-depth, multidimensional approach to poverty and inequality in the Region's population is needed.

Finally, health system reform processes aimed at institutional and structural changes in the health systems should not be conceived as discrete, short-term activities, but rather, as long-term initiatives. It should also be noted that while the two processes of change usually characterize different types of health system reform, both may simultaneously be present in some countries (4).

Although this type of study offers an analysis of access barriers as a source of information to correct policy-making (15-17), it has several limitations. First, the lack of baseline information limits the study design to the use of cross-sectional information, which reduces the capacity to infer causality, given the distance between the launch date of the reform and the first measurement used. In addition, the access and coverage variables do not necessarily cover the same time period as the reform processes in the countries studied. Furthermore, in some cases (Chile, Guatemala, and Mexico), the available information limited the comparison to between just two or three years, preventing the capture of substantive changes in the results. Finally, while this study offers an overview of the results achieved in equity, more robust studies are needed to systematize the monitoring of change processes in health systems and the impact of these changes on equity in health access and coverage.

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Lógicas de transformación de los sistemas de salud en América Latina y resultados en acceso y cobertura de salud

RESUMEN

Objetivo. Caracterizar los procesos de reforma del sistema de salud implementados en ocho países de América Latina y evaluar sus resultados en las condiciones de acceso y cobertura de salud.

Métodos. Se combina una caracterización de los procesos de transformación de los sistemas de salud de Chile, Colombia, El Salvador, Guatemala, México, Paraguay, Perú y Uruguay con la evaluación de sus condiciones de acceso y cobertura, mediante el uso de encuestas nacionales de hogares representativos de los países estudiados.

Resultados. Cinco países introdujeron cambios para ampliar la cobertura financiera, con perspectivas de atención primaria limitadas a la expansión de paquetes de servicios de salud, mientras que tres países priorizaron cambios en la organización de los servicios de salud, con una perspectiva más integral de la atención primaria de salud. Los países ubicados en el primer grupo aumentan la cobertura del seguro pero sin mejoras en el acceso a los servicios de salud. En el segundo grupo de países, aunque ha mostrado mejoras, persisten altos niveles de barreras de acceso.

Conclusiones. Las reformas de los sistemas de salud pueden caracterizarse en función del tipo de transformaciones promovidas. Las reformas centradas en expandir la cobertura de seguros mejoran la cobertura financiera, aunque no se traducen en cambios positivos en el acceso. Las reformas que priorizan la transformación en la organización de los servicios de salud logran avances en el acceso, pero aún persisten altos niveles de la población que reportan barreras de acceso en esos países. Las condiciones socioeconómicas de la población y la inestabilidad de las políticas son obstáculos para lograr avances más significativos.

Palabras clave Reforma de la atención de salud; cobertura de los servicios de salud; accesibilidad a los servicios de salud; atención primaria de salud.

Lógica da transformação dos sistemas de saúde na América Latina e resultados no acesso e cobertura de saúde

RESUMO

Objetivo. Caracterizar os processos de reforma do sistema de saúde implementados em oito países da América Latina e avaliar os resultados obtidos quanto ao acesso e cobertura de saúde.

Métodos. Foi realizada uma caracterização combinada dos processos de transformação dos sistemas de saúde do Chile, Colômbia, El Salvador, Guatemala, México, Paraguai, Peru e Uruguai com a avaliação da situação de acesso e cobertura de saúde a partir de dados obtidos em pesquisas nacionais de domicílios representativas dos países estudados.

Resultados. Cinco países empreenderam mudanças para ampliar a cobertura financeira, com uma perspectiva de atenção primária limitada à ampliação dos pacotes de serviços de saúde, e três países priorizaram mudanças na organização dos serviços de saúde, com uma perspectiva mais abrangente à atenção primária à saúde. Nos países do primeiro grupo, ocorreu a ampliação da cobertura do seguro de saúde, porém sem melhoria do acesso aos serviços. Nos países do segundo grupo, houve melhorias, mas continuam existindo grandes barreiras de acesso.

Conclusões. As reformas do sistema de saúde podem ser caracterizadas pelo tipo de transformação ocorrida. Reformas direcionadas a ampliar a cobertura do seguro de saúde aumentam a cobertura financeira, porém não resultam em mudanças favorecendo o acesso. As reformas que priorizam mudanças na organização dos serviços de saúde resultam em melhorias de acesso, porém persistem as barreiras de acesso a uma grande parcela da população nesses países. A condição socioeconômica da população e a instabilidade das políticas impedem alcançar um progresso mais significativo.

Palavras-chave Reforma dos serviços de saúde; cobertura de serviços de saúde; acesso aos serviços de saúde; atenção primária à saúde.